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Complaints against doctors in an accident and emergency department: a 10-year analysis

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SUMMARY

We carried out an analysis of complaints against doctors in our Accident and Emergency Department received from 1 January 1979 to 31 December 1988. There were 66 complainants in all, comprising 37 relatives, 21 patients and eight persons acting in a professional capacity. The majority of complaints (80 out of 125) were about poor communication and dissatisfaction with diagnosis and treatment. A small number of complainants had unrealistic expectations of the Accident and Emergency service. A total of 83.3% of complaints were against Senior House Officers who saw 61.3% of all patients. We concluded that an improvement in the communicative, diagnostic and therapeutic skills of doctors would minimize justified complaints.

INTRODUCTION

Complaints against hospital staff are not rare. In 1984 the Department of Health and Social Security recorded 22 000 written complaints in hospitals in England and Wales from 6 million in-patients and 50 million out-patients and A&E attendances (Stone, 1980). This gives a complaints rate of 0.393 per thousand attendances. 'Complaints are inevitable because doctors and patients, even if they come from the same cultural background, view ill health in very different ways' (Helman, 1985). The problem is how to ensure some communication between them in the clinical encounter. Patients complain for various reasons if they become dissatisfied with the service. The Department of Health and Social Security set up guidelines

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for dealing with such complaints (DHSS, 1981, 1985). The complaints analysed here were dealt with in accordance with these guidelines.

This analysis is primarily concerned with complaints and not litigation as the latter is fully discussed in Medical Defence Union and Medical Protection Society publications (MDU, 1987; MDS 1987 a&b). Although litigation is very important it is resorted to by a relatively small number of dissatisfied patients. In our case there were only four cases of litigation compared with 66 complainants. Richmond & Evans (1989) reported four settled cases of litigation (out of 13 solicitors enquiries) compared with 72 complainants.

PATIENTS AND METHODS

Complaints were registered through the Unit General Manager 'who is the designated complaints officer as proposed in the Hospital Complaints Procedure Act 1985' (DHSS, 1985). Complaints were made directly to him or they reached him via the A&E department. One complaint was made via the Community Health Council. The Unit General Manager's records were compared with those kept in our A&E Department to ensure that no complaints were missed. All complainants received a written reply after a thorough investigation of their complaints. All the correspondence was analysed and the results are reported in the following section.

RESULTS

There were 66 complainants in all. As a result of changes in health authority boundaries total hospital complaints numbers for our catchment area are available only from 1982. During the years 1982–1988 there were a total of 489 hospital complainants compared with 50 for A&E, i.e. complaints against A&E doctors were 10.2% of total hospital complaints.

Complainants

The 66 complainants comprised 37 relatives, 21 patients and eight persons acting in a professional capacity (see Table 1).

Sex

Among patients and relatives there were 33 female and 25 male complainants (see Table 1). This is similar to Schwartz & Overton's (1987) results who found that 60.2% of their complainants were female.

Attendance time

Complaints involved 32 patients seen between 9.00 and 17.00 hrs and 34 patients seen between 17.00 hrs and 9.00 hrs the next day and at weekends. The number of

Table 1. Table of complainants.

Relation	Number	Sub-total
Female Patients	11	
Mothers	8	
Wives	4	
Daughters	3	33
Fiancees	3	
Female Friends	2	
Nieces	2	
Male Patients	10	
Fathers	8	
Sons	4	25
Husband	1	
Son-in-Law	1	
Grandfather	1	
Professional		
Doctors	6	8
Ambulanceman	1	
Teacher	1	
Total		66

complainants per month over the 10 years studied is shown in Table 2. Complaints were at their maximum in January and July (even after excluding those against Locum Senior House Officers [SHOs]). Regular SHOs appointments terminate in January and July of each year. The monthly fluctuations in complaints had no direct relation to the number of patients seen per month (Table 2).

Numbers and rates

The number of complainants per year is listed in Table 3 which also shows the rate of complaints per thousand new cases. Our overall rate of 0.158 compares favourably with other published figures of 0.393 for England and Wales in 1984, (Stone, 1985) 0.290 for Cardiff (Richmond & Evans, 1989) and 1.078 for the William Beaumont Hospital, Royal Oak, Michigan, U.S.A. (Schwartz & Overton, 1987). One hundred and twenty-five complaints were made by the 66 complainants giving a mean of 1.9 complaints per patient. (Varying from one to four, see Table 4.) Table 5 shows rates of complaint by grade of doctor.

Table 2. Monthly complaints.

Month	Total no. of complainants	Total no. of patients seen
January	10	38556
February	5	36244
March	5	41672
April	2	44115
May	3	46900
June	3	46842
July	11	49112
August	6	45435
September	8	45949
October	7	44832
November	3	40609
December	3	41556
Total	66	521822

Table 3. Complainants per year and rates per 1000 new cases.

Year	No. of complainants	No. of new cases seen	Rates of complaint per 1000 new cases
1979	3	37081	0.081
1980	8	36542	0.219
1981	5	37321	0.134
1982	6	39475	0.152
*1983	12	36901	0.325
1984	11	42179	0.261
1985	3	45463	0.066
1986	7	46577	0.150
1987	6	47345	0.127
1988	5	47572	0.105
Total	66	416456	0.158

* Department changed site to a new hospital in 1983.

Table 4. Number of complaints per patient.

Number of complaints per patient	Number of patients
1	22
2	28
3	13
4	2

Table 5. Rates of complaint by grade of doctor.

Grade	No. of complaints	Total no. of patients seen	Rate 1000
Senior House Officer	55 (83.3%)	319816 (61.3%)	0.172
Registrar	8 (12.2%)	149013 (28.5%)	0.054
Consultant	2 (3%)	47353 (9.1%)	0.042
Clinical Assistant	1 (1.5%)	5640 (1.1%)	0.177
Total	66 (100%)	521822 (100%)	0.126

Waiting time

Patients and relatives complained only if the waiting time exceeded 90 min.

Substance of complaints

Fifty of the 66 patients involved in the complaints were involved in accidents (14 in road traffic accidents). The remainder were non-accidental emergencies. The majority of complaints were aboout poor communication, missed diagnosis and dissatisfaction with treatment (see Table 6). Fractures were missed in 16 patients, 14 of whom were not X-rayed at initial attendance. Two dislocations were missed (radial head, X-rayed; and proximal interphalangeal joint of finger, not X-rayed). There were two cases of foreign body in wounds missed (not X-rayed). Two tendon injuries (complete severance), two nerve injuries (ulnar nerve and digital nerve). two cases of serious sepsis, one case of myocardial infarction and one case of retinal detachment were missed.

EXAMPLES

Case 1

An 11-year-old boy attended with a history of knee pain following a fall at football. He was unable to walk on the affected leg. Examination revealed a small effusion in that knee and tenderness over the medial femoral condyle. He was diagnosed as having a sprained ligament. He was not X-rayed at the initial attendance. Subsequent X-ray on follow up showed a type II Salter Harris fracture of the lower femur. He now has disabling shortening of the leg.

Case 2

A 19-year-old girl fell on a dance floor on to broken glass. She sustained a laceration at the base of the thumb. She was noted to be unable to bend the thumb. Sensation was said to be present. The laceration was sutured. Subsequently she was found on follow-up to have severed the tendon of flexor pollicis longus and a digital nerve.

Table 6. Substance of complaints.

Problem	No. of complaints
Poor communication	28
Missed diagnosis	26
Dissatisfaction with treatment	26
Dissatisfaction with investigation	17
Dissatisfaction with history and examination	11
Waiting time	8
Unhappy with transport arrangements	7
Inappropriate attendance	2
Total	125

Case 3

A middle-aged lady involved in a road traffic accident attended with numerous abrasions and a few lacerations on the thighs. The lacerations were sutured. Later she was found to have a piece of glass in one of the lacerations.

Case 4

A 53-year-old man attended with chest pain of acute onset. His electrocardiograph was normal. He was allowed home. He died the next day of myocardial infarction.

Case 5

A 22-year-old man was seen at 3.15 a.m. with facial injuries sustained in a fight. The patient was noted to be drunk. He was suspected to have a fractured mandible (not told). He was asked to report at 9.00 a.m. on the same day for X-ray. He did not attend but went to another A&E Department instead where he was X-rayed and found to have a displaced fracture of the mandible which was fixed on the same day. He complained that we missed a fracture.

Case 6

A 19-year-old rugby player with a sprain of the lateral ligament of the ankle was treated with a support dressing and given a pair of crutches. His mother complained that he was not allowed an ambulance to take him home.

Dissatisfaction with treatment mostly involved delay in giving analgesia, and problems with the management of wounds. Some relatives felt that the patients should have been admitted.

In a small number of cases the complainants' expectations of the service were unrealistic.

Our billing complainants (three in all), all involved in road traffic accidents, also complained about the quality of treatment received. It is doubtful that these

complaints would have been made if the patients were not billed. In comparison one American study reported 135 billing complaints out of a total of 244 (Schwartz & Overton, 1987).

FINAL OUTCOME

The majority of the complaints were settled in stage 1 of the complaints procedure. Complainants were satisfied with a letter of explanation and an apology when one was indicated. In cases where it was felt that a meeting with the Consultant would be helpful such a meeting was offered but very few complainants attended.

There were 10 solicitors' enquiries of whom only two had complained to the hospital first. Four of the 10 subsequently initiated litigation proceedings.

Outcome of Solicitors' Enquiries/Litigation

Case A — Missed dislocation of finger was settled out of court for two thousand pounds.

Case B — Discharged myocardial infarction patient. Case settled out of court, the wife was compensated with £37 000.

Case C — Missed Slater-Harris type II fracture of lower femur. Health Authority agreed to settle out of court but disagreement on level of compensation continued.

Case D — Compression fracture of the third lumbar vertebra. The patient was X-rayed at the initial attendance but the fracture was missed. Health Authority agreed settlement out of court — final compensation not yet settled.

There are six other cases in which solicitors' enquiries were received but there are no further developments to date. Hospital case files have been closed in two of these (solicitors' enquiries received in 1980 and 1983).

DISCUSSION

A complaint represents a perceived failure of a doctor to deliver the expected standard of care. More often than not the patient/relative has been bothered by two or three events before voicing a complaint (see Table 3; Van de Leuv, 1987). Failure to communicate was the commmonest complaint in our cases (see Table 6). It was also a major factor in a large number of the other complaints. The communication problem was an important factor in drunken patients' failure to comply with medical instructions (eg. return the following morning for X-ray examination or to attend their General Practitioners' (GPs) surgery for removal of sutures) because they did not remember the instructions the next day. As a result of this study we now give written instructions to drunken patients regarding attendance in our Department and appointments to attend their GPs surgery for removal of sutures.

The majority of complaints about inadequate assessment (history, examintion and investigation), especially in elderly patients, were substantiated by missed diagnosis. Genuine complaints about inadequate treatment were similarly substantiated e.g. Cases 2 and 3 under Examples.

The commonest investigation complained about was failure to X-ray patients. Surprisingly the majority of patients who should have been X-rayed (9 out of 14 missed fractures) were seen during daylight hours when a full X-ray service was available.

It is interesting that complaints against SHOs (even after excluding those against Locums) were highest during their last month of service. However, the difference between the lowest and highest monthly complaints is not statistically significant.

CONCLUSION

A positive attitude should be taken to complaints by patients against medical staff. Important lessons will be learnt by viewing complaints as consumer feedback. An overwhelming majority of complainants are only looking for explanations to events that occurred to them in times of distress. Due to prevailing circumstances many of them have forgotten adequate explanations given at the time of these events. Any department may find regular analysis of complaints a useful addition to their audit procedures. This will highlight the areas where communicative, diagnostic and therapeutic skills need to be improved. We would advise that supervision of SHOs should be just as rigorous in their final months as in their first.

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